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AMENTIA AND DEMENTIA:

A CLINICO-PATHOLOGICAL STUDY.

BY

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Reprinted from the 'Journal of Mental Science,' October, 1905, *and January*, 1906.

London:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1906.

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AMENTIA AND DEMENTIA: A CLINICO-PATHOLOGICAL STUDY.

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CONTENTS.

HIGH-GRADE AMENTIA.

Group III.

RECURRENT CASES.

	Males.	Females.	Total.
(*a*) Relapsing	6	13	19
(*b*) Now chronic	11	17	28
Total	17	30	47

This group includes recurrent cases of insanity or cases subject to relapses from an apparently normal mental condition to one of mental alienation. The patients differ from those of the previous group in that during their lucid intervals they pass as normal sane individuals. They are, however, liable to become so far out of accord with an environment which would have little or no influence on normal individuals, that attacks of temporary mental alienation develop at regular or irregular intervals. In other words, the mental equilibrium of these patients is so unstable that it becomes upset by the

various influences which constitute the normal "stress" to which the several members of a civilised community are necessarily subject. Though the cases in this group grade insensibly into and, during their attacks, exhibit a mental symptomatology similar to that of those included in Group II, classes (*a*) and (*b*), the fact that they are sane during a greater or a lesser portion of their lives affords a sufficient reason for placing them in a separate group as one of the types of high-grade amentia.

As is the case generally in high-grade amentia, the ages of incidence of the several attacks are uncertain, and the symptomatology exhibited is various. An attack may be precipitated by the normal physiological changes occurring at any of the "critical" periods of life, or by any undue or unusual condition of "stress," whether toxic, physical, or mental, etc. A patient may, for example, suffer from one or more attacks of insanity during the period of adolescence, and may then develop another, some years later, after confinement, or may continue sane until the pre-senile or even the senile period of life. Other cases, again, may not suffer from any attack whatever until middle life or later, and in some instances no psychic phenomena of so abnormal a character as to necessitate an asylum *régime* may appear until even the senile period of life is reached. Whatever be the age of incidence, however, the result is recovery, after a varying period, without the development of an appreciable amount of dementia. The period elapsing between the recurring attacks of insanity varies in different cases, and is largely dependent on the inherent resistance of the individual to his environment. In cases of low resistance, the attacks may be almost or quite periodic, whereas if the resistance is greater many years may elapse before a recurrence of insanity. It is, in fact, probable that a large proportion of the cases of "recovery" from an attack of insanity relapse sooner or later, and that the remainder would also do so were it not that they die before the recurrence actually happens or that their environment has been made suitable to their capacity of resistance by their friends or relatives.

The symptomatology manifested during the attacks is as various as is the age-incidence of these. Whilst, however, in the case of the latter the important factors are the resistance of the individual and the external "stress" which is applied,

in that of the former individual temperament and general psychic experience are probably the determining causes of the phenomena manifested. The symptoms may be those associated with excitement or with depression, or a period of excitement may be followed by one of depression. The order of sanity, excitement, depression, and again sanity may always be the same, and each of these phases may even be of approximately the same respective duration in subsequent attacks, as in patients whose mental equilibrium is very unstable. The psychic disturbance may, however, be of an entirely different character in the several attacks, as in patients who are more stable mentally, and in whose cases environment is the most important factor in determining the incidence and even the course of a relapse. Almost any phase of psychic disturbance may exist during an attack, and if more than one phase occurs, each may vary in duration independently of the other. It is, nevertheless, common to find that the more regularly and the more frequently the attacks of insanity recur in a given individual, the more usually do they resemble one another both in symptomatology and in duration ; and this statement applies both to still relapsing cases, a proportion of whom are usually described as " folie circulaire," and to cases permanently under asylum treatment.

The usual, if not the invariable, result in cases which live long enough is a gradual shortening of the lucid intervals, with, finally, permanent confinement in asylums; and in a large proportion of the cases little or no dementia supervenes even when the patient has become aged, unless normal senile involution of the cortical neurones ensues, or any of the causes of progressive and secondary dementia interfere with the course of the case.

Amongst the exciting causes of the onset of attacks, alcoholic excess is one of the most potent, but it does not, in the type of case under consideration, necessarily produce any cerebral dissolution. Cases, in fact, which readily lose their mental equilibrium under the influence of alcohol may be brought before a magistrate scores of times before or without going to asylums at all, and may continue up to old age without the development of dementia. On the other hand, however, cases, which exhibit greater resistance to breakdown, will, under the prolonged and excessive abuse of alcohol, with the other necessarily concurrent

mental and physical forms of "stress," sooner or later develop some or even considerable dementia.

In cases of the type under consideration it is not uncommon to find a premonition of the incidence of an attack, and patients after recovery may graphically describe their efforts at self-control and how these finally became ineffectual. In some instances there is complete recollection of the attack, and the patient is able to state exactly what occurred during it, and to describe his utter inability to control his thoughts and actions. In other cases, again, especially when the attack is of sudden onset and great severity, the patient has no recollection of what has occurred, and consequently on recovery shows complete loss of memory regarding the events during his illness. In such severe cases the patients, as regards their behaviour, their general appearance, and even their facial expression, may be quite unrecognisable. Modest and quiet girls, for example, become talkative, noisy, excited, and erotic, and pleasant and respectable women become foul-mouthed fiends.

In no type of high-grade amentia is the homologue in sane individuals more readily discoverable than in the group of cases under consideration ; and, though it be at the risk of a charge of exaggeration, the writer will now proceed to illustrate what appears to be the psychic relationship between recurrent insanity on the one hand and the lapses of control over the emotions, words, and actions which occur in the normal individual on the other. The ordinary sane person usually exercises relatively little voluntary control over his emotions or intellectual processes, but glides along according to accident of environment and pre-arranged duties ; and all individuals are subject to more or less severe lapses of voluntary control. Common examples of this are the excitement or depression which lasts for hours or days under unusual circumstances or after startling occurrences. In the presence of strangers one person may talk incessantly and volubly from sheer nervousness, whilst another can hardly be got to speak a word. Other individuals, again, whenever they converse, even with strangers, are quite unable to refrain from repeating all kinds of fact or gossip which ought to be kept secret, and afterwards are quite aware of their delinquency. A girl may be violently excited for hours before a ball or after the advent of a new gown ; and a man, after a game of golf or cricket, may be a perfect nuisance

to uninterested listeners by persisting in recounting his exploits, and particularly in repeating what would have happened had so-and-so *not* occurred. More marked examples of loss of voluntary control are the violent "passions" or "sulks" which in some individuals are precipitated by apparently inadequate causes, and these, again, pale before the extreme excitement and "delirium tremens" of acute alcoholism. To these examples may finally be added the tendency, as a natural reaction to prolonged application to work or to undue restraint, to break control for a few hours or more and to "go on the bust," which is so extremely common in nearly all individuals, and which, where resistance to environment is at all weak, may end in undesirable results. The last instance is especially instructive owing to the readiness with which it recalls the severe efforts to keep sane which are made by many cases of insanity, who suffer from frequent relapses, and who, during their lucid intervals, are most anxious to obtain their discharge and to return to their friends.

Group III.—Class (a).

Relapsing Cases.

This class contains 19 cases, of whom 6 are males and 13 are females.

Though, from what has already been stated, the number of cases in this class is no indication of the actual proportion of lunatics of the type under consideration, it serves a useful purpose in that it shows that patients suffering from relapses are not infrequently met with in an asylum population during any given period of time, in this instance a few months. As will be seen later, in Part III of the present paper, the total of 728 cases includes 48 examples of senile or "worn out" dementia, which were primarily cases of recurrent insanity, and 75 examples which had continued in asylums since primary certification. Both these numbers represent an accumulation of cases of varying duration, and their exact use would be beset with fallacies; but they at any rate indicate that the proportion of relapsing to primarily incurable cases is high, and they are therefore made use of in the absence of more trustworthy data. The writer does not, however, wish to attach any undue importance to these figures; for, though the

average duration of life in relapsing cases is probably much higher than it is in the chronic insane, the proportion of the former figure to the latter still perhaps remains higher than an average recovery rate of about 30 *per cent.* would allow of, even if the majority of these cases relapsed.

The symptomatology exhibited during recurrences of mental alienation is various and difficult to classify into types. In a large proportion of cases, however, certain emotional states, namely excitement, depression, and fear, predominate, and these may be associated with or may result in impulsive actions, *e.g.*, violence to others, destructiveness, and attempts at suicide, the last usually by such methods as can be carried out without premeditation.

Cases of the excited type are boisterous, restless, violent, noisy, mischievous, and imitative. They possess only the slightest power of fixing the attention and are unable to settle to anything, but react to sensory stimuli so rapidly that their actions appear wild and their speech incoherent. Their attention flits to and fro ; whatever they begin to do, or say, or sing they leave unfinished, and their mental functions at times appear to be in a state of confusion. With patience it may be possible to get them to write their names, but they either leave the name unfinished, or cover it with flourishes, or end by performing some violent or absurd antic. They can usually be got to answer occasional questions, at any rate if their attention can be attracted long enough to enable them to understand them ; and therefore short questions are more frequently replied to than long ones. They often, however, give inconsequent or inapposite replies, and they may make voluntary remarks, usually about objects near them or sounds heard by them, which appear quite incoherent unless both the patient and his surroundings are most carefully and minutely studied. Such replies and remarks usually form sentences and phrases which in themselves are verbally correct, and in cases where the ideation is so rapid, and the attention is so flitting that no sequence of ideas can be traced, this characteristic of verbal correctness in the phrases and sentences spoken is still maintained. In the more marked cases of exaggerated reaction to external stimuli, where the capacity of attention is practically absent, only the shortest phrases, or single words even, may be repeated, and here especially association by similarity becomes evident,

and whole strings of words which rhyme or sound alike may be repeated. Beyond this stage it is not usual for sensory and ideational hyper-reaction to pass in cases of the type now under consideration, for on the one hand aberrant and grotesque ideational processes generally occur in cases belonging to Classes (*b*), (*c*), and (*d*) of the preceding group, who are never really sane, and on the other, still more abnormal ideation is, at any rate as a rule, inconsistent with recovery, and cases exhibiting it are in the preliminary stages to or have actually developed more or less dementia. Hallucinations are not common in cases of relapsing insanity, unless the attack is precipitated by alcoholic excess or some other cause of cerebral toxæmia ; and many examples are credited with this symptom when the explanation of the phenomena exhibited is to be found in the hyper-æsthesia of the special senses, which occurs in association with an abnormally rapid reaction to the sensations experienced.

In certain cases, of the excited and apprehensive types especially, it is not uncommon to meet with a psychic state which, without analysis, might be mistaken for confusion, but which is really allied, on the one hand, to the inability to think which occurs in some persons owing to nervousness, *e.g.*, a student at a *vivâ-voce* examination, and, on the other, to the thoughtless remarks of children, or of persons who happen to be talking "through the backs of their heads." As an example of the former may be mentioned a patient who, on being asked her name, appeared quite uncertain as to her personal identity, asked the nurse who she was, and finally mentioned certain marks of identification which she possessed, and which would enable the question to be settled ; and, of the latter, a patient who, when asked to open her mouth and show her teeth, said that she would like to have all her teeth removed and requested me to at once perform the operation.

Cases of the depressed type are more or less melancholic, and, if the depression is not so profound as to annul the capacity of attention, the patient is either unable to give a reason for his condition or he affords an intelligent explanation, which, in many cases at least, is in essentials true. At times a correct or possible cause may be grossly exaggerated, but the elaborate introspection seen in developing delusional cases does not occur. A certain patient gave, as the cause of his first

relapse, his anxiety about his aged mother, who had recently become insane, and his mother gave as the cause of her attack her anxiety about her son, who had just before developed his first attack of insanity. The son, again, as the cause of his first attack, which became obvious owing to a determined attempt to cut his throat, stated that he had begun to think that he could not help it, as it was born in him, for his grandmother was like his mother in the fact that she suffered from depression at times. The son, during the period he was under observation, recovered from his second attack, again relapsed, and once more recovered; and the mother remained an inmate of the asylum and suffered periodically from mild depression. As an example of a possible but exaggerated cause, which the patient, on recovery, ceased to accept, may be mentioned an individual who stated that his attack began owing to the worry from which he suffered owing to his having made a mistake in his accounts, which was the cause of great monetary loss to his employers.

Fear or apprehensiveness is the important symptom in many of the cases in the class under consideration. The patient is perfectly frantic owing to terror which he cannot explain or give a reason for. The emotion is in such a case not the apprehensiveness of a confused or lost patient, but is downright honest fear, and it may lead to violent behaviour or to sudden and unpremeditated attempts at suicide. One such patient could not be kept in bed a moment, and would not stay in a side-room unless the door was fastened. The opening of the door resulted in frantic attempts to escape, which, on one occasion, led to a struggle between the patient and a nurse, who, contrary to instructions, had entered the room alone. The contest lasted until they were both exhausted, and were found thus by another patrol nurse. This patient, in her frenzy, on more than one occasion mistook one of the medical officers for a relative, implored him to protect her, and clasped hold of him so tightly that he was with great difficulty removed from her clutches. Cases of this type do not form an especial variety but grade insensibly into those already described.

As has already been stated, relapsing cases frequently suffer from impulses. Some cases snatch at everything within their reach, either from acquisitiveness or mischief; others destroy out of wantonness any article in their vicinity, and others, again,

are violent and dangerous. The most serious impulse, however, is that prompted by fear or misery, namely, an unpremeditated attempt at suicide by, *e.g.*, drowning, jumping out of windows, cutting the throat, or strangulation. In some instances the act appears to be carried out either without any motive at all, or from an entirely inadequate one, as in the case of a patient who awoke feeling that he could not go to his work and that everything had gone wrong, and who straightway ran downstairs and attempted to cut his throat. It is quite probable that in some cases the motive for a sudden attempt at suicide is elaborated after the act has been unsuccessfully accomplished; and that at least a number of successful suicides "during temporary insanity" are unrecognised examples of the type of case at present under description.

As the cases described in this section recover and are discharged, it is only to be expected that during their residence in asylums they are useful workers. Of the 6 males referred to as belonging to this class, 4 worked well; one, an educated and eccentric man, refused to work usefully; and one, who suffered from phthisis, was unable to work and eventually died. Of the 13 females, 12 were good workers, and one, who suffered from chorea, was therefore unable to work usefully, and, after discharge, soon relapsed and was readmitted. The following five cases are average examples of those referred to in the section:

Recurrent Melancholia, with Suicidal Impulses.

Case 182.—D. D—, male, married, carpenter, æt. 41. Certified 1½ years, son of No. 211.

Patient is recovering from an attack of recurrent melancholia of one and a half years' duration. He is somewhat lively in manner, and is talkative and inquisitive. He tries to read what I am writing and readily tells me the date when asked, though he first looks at a newspaper to make certain. His memory for both recent and remote events is perfect, and he gives a clear account of his case with very little cross-examination.

His first attack began suddenly three and a half years ago. Without any warning he got up out of bed, ran into the scullery, cut his throat, and was taken to the hospital. He did this because he felt that everything was going wrong and that he could not do his work if he went to it. If he could not work his wife and family would "go to the dogs," so he suddenly felt that he must commit suicide, and he did so. He never meditated suicide till that very morning, and then it was a sudden

impulse, and he has not had such an one since. He was in the asylum for eleven months as a result of this attempt. He was then sent out on trial for a month, but at the end of this period he was taken to a workhouse for a time and was then sent to another asylum, where he remained for four months, and from which he was discharged recovered. He then went home and worked up a small lodging-house. He did well for two and a half months, and then received a severe shock owing to his mother becoming insane. He became very depressed and felt unable to work. He began to think that people looked down on him as a lunatic, and he worried a good deal about this. He has always been accustomed to dream frequently, and, as a rule, the dreams are of a pleasant nature. Just before his relapse, five months later, he, however, had a most unpleasant dream which he remembers vividly. He "dreamed that he was down in a cellar or cave, and that there was a window in it which opened on a balcony. He felt irresistibly that he must run out of the window and escape, and when he ran out someone was waiting to take him."

He gives a hereditary reason for his illness. He says that he has begun to think that he couldn't help it as it is born in him. His grandmother was like his mother in the fact that she suffered from depression at times, and he thinks that he is also like her. He is very sorry for what he has done, but thinks it is a misfortune rather than a fault. He, however, is anxious "to know if he has anything physically the matter with him."

For some months patient continued to be interfering, quarrelsome, and mischievous, and he was often in trouble with other patients. He then recovered and was discharged.

Some months later he was admitted in a condition of profound melancholia. He was a physical wreck and suffered from severe and recent gonorrhœa. He again improved and was again discharged recovered.

Marked Eccentricity, with Recurrent Attacks of Mania.

Case 184.—G. S. T—, male, married, carver, æt. 56. During the past fifteen to twenty years patient has been erratic and peculiar and has suffered from attacks of mania. He was in an asylum some months ago and also four years ago.

He is at present in a condition of wild excitement. He is excited, restless, and violent and most destructive to everything near him. He tears his clothes, throws about and breaks the chairs, etc., and can only be managed when in a padded room in strong clothing. He is noisy and shouts loudly and unintelligibly and gesticulates wildly. He clasps his hands, jumps up and strikes out, etc.

When I endeavour to attract his attention he shows that he possesses some power of attention. He becomes inquisitive and tries to seize my note-book and pencil. He makes a face at me, he points to his teeth and he tries to get me to shake hands. No satisfactory replies to questions can be obtained owing to his rapid reaction to sensory stimuli, but he says he represents the Queen and Crown, etc., and the more he is taken notice of the more grandiose he becomes. He is,

however, quite rational and able to reply to questions if they are presented in a suitable manner, for he writes accurate replies when given a pencil and note-book.

Patient settled down gradually and at times was quite well behaved and apparently convalescent. He was, however, a good deal of trouble as he was constantly worrying some one or other, by correspondence or otherwise, about trifles, and he steadily refused to work. Eventually, some months later, he was removed from the asylum by his friends, and was then in all probability in what has been his normal mental condition during the past twenty years or so. He was an intelligent, well-educated, and clever man, and, in spite of the trouble he caused, was much liked and respected.

Recurrent Mania, with Apprehensiveness.

Case 188.—E. S—, female, single, domestic servant, æt. 34. Previous attacks at the ages of 17, 21, and 33. No history of intemperance.

Patient on admission is a pale, restless woman, who is rather talkative and asks me to let her tell me what she has done. She only struggled with her brother in the house because she wanted to go for a walk. She has had no sleep for two or three nights. She thought she heard someone calling, "You ought to come up and see mother." Her brother said it was nothing. She asks me if her mother, Charlotte Clarke, later S—, is here.

She knows the day, month, and year, and approximately the date. She gives a fairly clear account of herself. She first went to an asylum when she was 17 or 18 years of age owing to brain fever, and she was there seven and a half months. She was in this asylum two or three times and was then in another asylum, whence she was discharged to the union. Then she went out to service. About a year ago she was again in an asylum for two months. She does not give this account very clearly and has difficulty in remembering details, and often returns to a question previously asked her, and adds the information.

About seven or eight years ago her baby Nellie was born, and she died when $7\frac{1}{2}$ months old. Patient knows who was the father of the child.

She at times shows much confusion during her anxious efforts to remember and to give information. She would, *e.g.*, very much like to see her sister to find out whether she is married. Then she says that she has lived at home since she last left the asylum, and adds, apparently *apropos* of nothing, that she is certain that one of the doctors here was known to her at another asylum she names (untrue). She wants to know if the people here thinks she is someone else, because one day she thought that she was someone else. She used to think that she was her brother. She says she used to have some little marks on her fingernails, and she might have been known by them to be herself. She often asks the nurse to confirm what she says, even if it is about a matter on which it is obviously impossible to do so. She does not seem to appreciate that we are all strangers to her. She seems to think that we must be friends, and she asks me if I am very much worried about her. Every now and then she clears of her confusion somewhat, *e.g.*, she

suddenly asks me whether she has told me she had a child seven or eight years ago, Nellie, who died, æt. 7½ months. She then adds that she thought she was going to have another two years ago, but nothing came of it. She fidgets with her hands and whispers to herself when left alone.

There is no history of alcoholic excess, and she does not resemble a case of alcoholic confusion. She is not improbably partially confused, owing to a draught which she says was administered last night (before admission).

On admission patient was extremely nervous and apprehensive, and she was readily frightened. She continued in this condition for several days, could not be kept in bed at night, and would not stay in a single room unless the door was fastened. She was almost frantic when the door was opened, and seized hold of anyone near and struggled like an eel to get away. On one occasion when a night-nurse, contrary to instructions, opened the door when alone, she and the patient struggled on the floor of the room for upwards of an hour till another nurse passed on her round.

This patient rapidly improved, and was discharged recovered after a residence of four months.

Extremely Acute Recurrent Mania.

Case 192.—M. C. E—, female, married, housewife, æt. 39. Nervous attack seven years ago. Father and sister insane.

An excited, violent, impulsive, and mischievous woman whose attention it is almost impossible to fix even for a moment. She at once asks me why the b——y h——l I don't shave myself. Then she picks up the admission book, tries to get hold of my stethoscope, pulls my ear, rubs my hair, and then rapidly reads her admission paper aloud. She is as lively as a monkey and as mischievous, but is also dangerous. Whilst taking her case she twice slapped my face and once struck me on the jaw. She at times gesticulates in a vicious manner, and at others sings and talks continuously and inconsequently, but not incoherently. When asked to write her name she takes the pencil and complies with the request, ending with some violent and irregular strokes of the pencil, which she finally hurls in my face :

The patient rapidly recovered, became clean and tidy and well-behaved, and a good worker, and was discharged recovered after some months' residence.

Presenile Mania, recurrent after an Interval of Twenty Years.

Case 199.—M. J. F—, female, married, housewife, æt. 50. Previous attacks at the age of 30, and also three months before her present admission.

A restless, excited, violent woman who will not stay in bed. She laughs, springs about, and rapidly utters a conglomeration of incoherent

words and phrases. She picks up pencils or other articles that happe to be near her, imitates what is done or said in her presence, and at times gets quite violent. Age? "One pound twelve and sixpence I owe Dr. P—," then adds her name. Age? "Ten years older than you—44." "Dr. W— knows. Three months old I—." "Twelve and sixpence I owe you, sir." "So she seems to be, 3rd of May." "Look there" (pointing to a plant), "we've bought that for tenpence, sorry we had it." Throws a kiss at me. Then says, "13th June, wide, wide world. 23rd April, mind your business." "I beg your pardon, Dr. W—, you gave me a sovereign," etc.

Patient rapidly recovered except for a certain amount of dulness and slowness, probably associated with her fairly marked deafness. She relapsed several times for short periods during the next twelve months, and was eventually discharged recovered.

Group III.—Class (b).

Relapsing Cases who are under Permanent Treatment.

This class contains 28 cases, of whom 11 are males and 17 are females.

The chief constituents of the class are cases in whom the lucid intervals have become too short to make their discharge possible, or who rapidly relapse in consequence of the change of environment following discharge. The class also includes several examples of fairly-marked degeneracy who have succeeded in passing for normal individuals during a part of their lives, and who have, in consequence of prolonged confinement in asylums, become degraded to a much lower mental level. These cases, of which No. 205 is an example, have, in fact, lived in a refractory ward like beasts for so long a period that they have practically become lower animals without actual loss of intelligence. This condition of degradation finds its sane homologue in the case of well-bred "ne'er-do-weels" who, *e.g.*, join the army as privates and, after years of rough-and-tumble existence in this capacity, resemble, except for occasional glimpses of culture, the class with which they have mixed, in their actions and speech and in the general coarseness of their moral tone.

These degraded cases in many instances exactly resemble other types in symptomatology, and only differ in the fact that they have once been "sane" individuals and were originally of

the relapsing class. A difficulty thus arises, in the absence of a personal history, in distinguishing them from certain cases belonging to Classes (*a*), (*b*), and (*c*) of Group II ; and similarly cases belonging to Classes (*c*) and (*d*) of Group II are often with difficulty distinguishable from many of the systematised delusional cases described under Group VI. Far, however, from being a flaw in the general argument contained in the present paper, this gradual shading of type into type is important evidence of the relationship which exists between all the cases described under the term " high-grade amentia," for the separate groups into which the cases are divided are employed for convenience of exposition rather than with the object of suggesting that these several groups contain specific types of mental disease.

The recurrent cases of higher type than the preceding differ from these in possessing periodic intervals during which they are medically though not legally "sane." The prominent symptoms in these cases are maniacal excitement and melancholic depression, and the time relationship of these to one another and to the lucid interval varies in different cases, but is usually fairly periodic. Some cases may suffer from excitement only, and some from depression only, or the maniacal state may last a longer or a shorter period than the melancholic. It is even possible, as has already been remarked, to make the general statement, with reference to the cases contained in both the present and the preceding classes, that the shorter the duration of the lucid intervals is, the more the relapses resemble one another, in any individual case, in both symptomatology and duration ; and the longer the duration of the lucid intervals is, the less the relapses may be expected to resemble one another in either symptomatology or duration.

In their capacity for useful work, the cases in this class, during their lucid intervals, resemble those in the preceding. Of the 11 males, 9 were good workers, 1 refused to work, and 1 was permanently mentally incapable of work ; and of the 17 females, 5 were good, 3 were ordinary, and 2 were poor workers, 3 refused to work, and 4 were permanently mentally incapable of work.

The following six cases are inserted as illustrative examples :

Recurrent Mania, much Mental Degradation.

Case 205.—H. W. A—, male, single, draper, æt. 46. Certified twelve years and previous attack at the age of 27.

A dull-looking man. Eyes rather close together. Forehead low and narrow. Ears large and without lobules. He gives his name as Alec A—. Age? "That I couldn't tell you, sir." He was born on May 13th, 1857, but cannot reckon his age from this. When I press him he stamps on the floor and then asks if the wood is "wood, wheat, hops, or Puck and the fairy?" He says he doesn't know where he is, and has come from "mother's womb." He at times eyes me curiously. He writes his name correctly, though he gave it as "Alec A—." When I say "Alec," he says "Ain't Harry Alec?" When asked if he has ever heard of the asylum from which he has come, he says, "Yes, Hop-garden, ain't it?" Asked if he has been there, he says, "Yes, was at St. John's Wood, making bricks." He then begins voluntarily to make such remarks as "There are 52 weeks in a year and 1760 days in a year," and asks me to suppose that "there isn't fifty-two weeks in a year." I then ask the number of days in a week, and he says, "Seven, and 12.30 is the smallest hour of the morning and nearly one o'clock."

He is untidy and filthy and degraded in his habits. He eats filth and fæces—and on one occasion ate a dressing which had been applied to a cut on his head—and he drinks urine and the contents of spittoons. He is disgusting in his behaviour and very destructive to clothing, etc. He never works, and is at times very troublesome.

Recurrent Melancholia of long Duration.

Case 208.—H. W—, male, single, farmer, æt. 59. Certified $22\frac{1}{4}$ years and had several previous attacks.

A dull, depressed-looking man, with bright eyes and a respectful manner. Palate V-shaped and very narrow in front, and not high. No lobules to ears.

He gives his name correctly. Was born on March 6th, 1844, and the present year is 1903, and therefore he is 59 years of age. He knows quite correctly the present day, date, month and year, and also the date of his admission here. He knows from what asylum he has come. He went there on August 3rd, 1881, and therefore was there 23 years. He did various kinds of work in that institution. He worked in the dining-hall and the stores chiefly. He does not smoke.

He is very ill, and he went to that asylum owing to being very ill. Now and then he suffers from dreams, but never from hallucinations. He complains a good deal of dyspepsia. "No doubt there is an enemy, but where it is I couldn't tell." He has "not been before the County Bench. I was summoned once before the County Bench for trespass and carrying and using a gun." He does not know who sent him here. They had orders at the other asylum to release him, but they didn't do so and sent him here. He supposed that this was ordered by "the onlookers." He is very dull and slow and hypochondriacal and is much worried about his different ailments, real or fancied, but especially about

a rupture from which he suffers. In spite of this, however, he is quiet and well-behaved and works willingly and industriously.

Recurrent Melancholia of long Duration without Dementia in a Patient æt. 76.

Case 211.—E. D—, female, widow, no occupation, æt. 76. Certified since the age of 74, and has suffered from attacks of melancholia since the age of 37. Son insane (No. 182), and also a relapsing case.

A healthy and well-nourished old woman who is somewhat apathetic, as a rule, but is nervous and fidgety. Her memory is good, her intelligence is normal, and she can give a clear and quite satisfactory account of herself. Her present attack was precipitated by worry over her son, who had recently recovered from an attack of melancholia and was causing a good deal of anxiety. He relapsed shortly after she was sent to the asylum. She is more concerned about her son than about her own condition, and frequently asks to see him or sends him small presents. At uncertain intervals she suffers from mild depression, when she becomes tearful and miserable for a few days at a time. She is somewhat hypochondriacal, petted, and irritable, but is in relatively good health for her advanced age. She constantly asks for her discharge, and regularly corresponds with her family and friends. She attends to herself, makes her bed, etc., and behaves exactly like an ordinary decent old woman. She also does a little dusting in the ward, and she sews well as regards quality of work, though she does not do very much.

Recurrent Mania of long Duration, with still frequent Relapses.

Case 215.—E. S—, female, single, servant, æt. 67. Certified since the age of 43. A previous attack at the age of 41. Son in the asylum (No. 24), an imbecile of moderate intelligence.

An intelligent-looking old woman who smiles in a pleasant manner, and readily gives a fairly clear account of herself. At present, during a lucid interval, her memory, apart from lapses during her attacks, and intelligence are good. She talks sensibly and rationally and asks many questions about what has happened during her last attack.

The lucid intervals are short, lasting a few days to a few weeks at most, and are followed by a much more lengthy attack of maniacal excitement, during which she is a totally different woman. She looks during these attacks a veritable fiend, and is excited, noisy, violent, spiteful, and dangerous, also destructive and of filthy habits. She is abusive and most foul-mouthed, and is possessed of remarkable activity and endurance considering her age and apparently delicate health.

The period of excitement is followed sooner or later by a shorter period of depression, during which she is silent and moody and feeble, and from which she gradually awakens to lucidity. For several days before finally becoming cheerful she talks readily and rationally and asks questions about her attack. She is pleased to see her son during her lucid intervals, and often asks after him.

Recurrent Mania of Forty-four Years' Duration, with still frequent Relapses.

CASE 216.—M. A. M—, female, married, no occupation, æt. 64. Certified since the age of 49, and has suffered from recurrent attacks of insanity since the age of 20.

A lively old maniac, who is devouring bread as if she had not had anything to eat for a week. She at once asks me if I am doing a bit of shorthand work, and wants badly to know what I am writing. Her memory is perfect, and her intelligence is normal. She rapidly gives me full details of her past life, and when I turn over a leaf remarks that "I have soon filled a page with her logic." She was married, during a lucid interval, at the age of 42, and has no family. She was kept, she says, in the last asylum, "because Dr. — is an old fool," and then she shakes with laughter. During physical examination she squirms and rolls about, laughs almost without intermission, and wants to know "what the devil are you doing?" She places her hands on her groins and is very anxious to be covered whilst I am examining her abdomen, and when her nightdress is taken off she covers up her breasts and laughs in an erotic manner.

The patient for several weeks at a time was a useful worker, but was jovial, excitable, garrulous, and erotic. She then relapsed, and for a varying period was excited, noisy, violent, and foul-mouthed. This attack was then followed by a shorter, but also variable, period of depression, during which she was reserved, silent and lachrymose, and after which the lucid interval developed gradually. She was at times difficult to get on with, but was a favourite.

Recurrent Mania of Periodic Type since the Climacteric Period.

CASE 220.—M. W—, female, married, housewife, æt. 57. Previous attacks at the ages of 49 and 53.

An excited, restless, noisy and violent woman, who shouts, sings, laughs, and throws her limbs about. She at times plays with her fingers, tries to tear the sheet with her few remaining teeth, pats her limbs, and at the same time utters rapidly, with occasional pauses, such phrases etc., as the following: "What can I do? my boys are all girls. I can get nowhere. I'm a beggar outside Calvey. I say, my boys, I'm proud of you, George IV. and Henry VIII. You've got to meet the one you hate. Salome, I hate you." She covers her head with the sheet and then speaks of "dark things and light things." "Covered again in No. 2 and revealed in No. 3, and bless and kiss in No. 3 the Royal." Then she lies quietly for a few moments. "Cover A B C, Cover. Cover what you never did, though. Incline my daughter unto me, incline, decline, recline, my fair lady. I'll fair lady you." She takes practically no notice of her surroundings, and her attention is very difficult to retain even for a moment. She does not always react to external stimuli, but at times she responds with extreme rapidity. Once she suddenly snatched my handkerchief from me, but otherwise took little or no notice of my presence.

The patient recovered steadily, and was a good and willing worker for several weeks. She was then discharged, but she relapsed at once. She rapidly recovered and some months later she was again discharged.

Group IV.

HYSTERIA.

Examples of true hysteria are relatively rare in asylum populations, and in the present series of cases there are but six instances amongst the 728 patients, and all these are of the female sex. The writer has, however, during his asylum experience, seen more than one case of genuine hysteria in the male sex.

The cases contained in this group are examples of the more severe forms of hysteria which either are unmanageable at home, or, possessing no suitable home, drift into workhouses and eventually into asylums. As would *à priori* be expected, all are recurrent cases, and have been previously in asylums, and in those instances where a satisfactory history exists, the patients had shown symptoms for years before their first certification.

Of the six cases, 5 are single women and one is married. The last shows marked stigmata of degeneracy, has defective articulation, is simple-minded and of low intelligence, and is very unstable, emotional, and hysterical. How she succeeded in getting married is a mystery. Two of the 6 cases are good workers, 1 is an ordinary worker, 2 refuse to work, and 1 is physically incapable of work of any kind.

In general symptomatology, apart from hysterical manifestations, the cases grade on the one hand into those of Group II, Class *b*, namely, "simple emotional chronic mania," and on the other into those of Group V, Class *b*, namely, "high-grade amentia with epileptic mania."

As from the aspect of pure hysteria the number of cases in the group under consideration is too small to justify any symptomatological deductions, the writer has necessarily to fall back on his asylum experience in order to obtain a basis for the following general statements concerning the types of hysterical patient which are found in asylum practice. The following varieties of case, which are not to be considered either as distinct entities or as representing all the types which occur

in asylums, fairly completely summarise the writer's experience of asylum hysteria.

(*a*) Cases of marked hysteria or hystero-epilepsy who suffer from attacks of maniacal excitement much resembling those which occur in cases of "high-grade amentia with epileptic mania" (see p. 11).

(*b*) Quieter cases, who at times work industriously but who are emotional and unstable, possess more or less marked hysterogenic zones, and suffer from hysterical attacks. These patients somewhat resemble, and grade into, cases of "simple emotional chronic mania" (Vol. LI, p. 528).

(*c*) Cases whose symptomatology is somewhat analogous to a hystero-epileptic state with a duration of weeks or months. These patients may be relatively or apparently sane for considerable periods. They then suffer from trance-like conditions, also lasting for considerable periods, during which they are as flaccid and inanimate as a recent corpse and have to be fed and attended to in every way. They may be wet and dirty, or they may secretly get up and use the commode. They, after a variable period, may exhibit grand movements and emotional attitudes, during which they alternate between this mental state and the previous one. Such a patient, when in bed, has been seen to hold her arm vertically towards the ceiling, with the forefinger pointed upwards and the whole limb rigid, for hours at a time, and has for similar periods performed movements of wide range with an utter disregard of consequences.

(*d*) Lazy, well-nourished patients who sit all day like dements or cases of stupor and never work, but who are very erotic in the presence of the members of the opposite sex. Their eyes are bright and wakeful, and they readily smile. They manifest hysterical phenomena on stimulation of the various hysterogenic zones, and their physical development is surprisingly good.

(*e*) Cases who show various types of "functional" paralysis, *e.g.*, monoplegia, paraplegia, etc. This condition has usually lasted so long that organic changes, which render cure impossible, have occurred in the muscles, tendons, and joints.

Of the six cases contained in the present group, the following two are inserted for the purposes of illustration.

Hysteria in a Case of marked High-grade Amentia.

Case 229.—E. W—, female, single, no occupation, æt. 31. Has shown symptoms for eight or nine years, and previous to these she had a "seizure," which curved her to the left side. Was in an asylum three years ago for several months.

Face expressionless. Forehead smooth. Silly vacuous grin. On watching her she soon becomes hysterical. Her eyebrows begin to act, her eyes suffuse, and her carotids throb. Just as she is beginning to weep I suggest "Which is it to be?" and she at once shakes with laughter. Soon, however, this emotional storm ends in a fit of weeping, which stops abruptly under pressure on the left infra-mammary hysterogenic zone, and leaves her composed.

She then gives her name and age and when she came and where she has come from, but not the name of this asylum (she was admitted yesterday). She knows the day and the name and part of the month, but not the exact date. She was previously in an asylum, but she "never put the date down when she went." She was there six months, and it must be "free or four" years since she left. She is childish in speech and behaviour. She says her mother remarked that she was much better when she left the asylum, and then adds, "but I never went in the town in B—," meaning that she was not upset by seeing people.

She has at times typical hysterical attacks, which are readily stopped by suggestion, and she is readily put to sleep at night, when troublesome, in the same way. On the other hand, the suggestion of a swelling in her throat brings on an attack.

During her residence she was clean in her habits and easy to get on with, but she never did any work. She washed her head in cold water every morning, and attended, more or less, to herself. She was very noisy, but was never spiteful, and was fond of singing and dancing. When in the airing court, if not standing or sitting, she used to run about rather than walk. When excited she would knock her head about and bang it on a window-frame, or she would do extraordinary things, *e.g.*, say she was a "lady sanitary inspector," and go round pulling the plugs, pulling doors off their hinges, and trying to pull down the water-pipes, etc. She at variable intervals suffered from convulsions, which were sometimes hysterical and at others hystero-epileptic.

Hystero-Epilepsy, Double Personality, Mental Degradation.

Case 232.—E. G. B. M—, female, single, domestic servant, æt. 37. Certified since the age of 25, and previously in an asylum at the age of 24. Maternal uncle insane.

A very neurotic-looking woman with blinking eyes, a narrow peaked forehead, and a small jaw. She usually puts on a sardonic grin when noticed. Her voice is thick and lisping as if she had a perforated palate, but this is not the case, though there is a scar in the middle line.

She is a marked case of hysteria, and exhibits a condition which amounts to an alternating personality.

At rare intervals she is quiet and well-behaved, denies her name, readily reacts to suggestion, and suffers from attacks of typical hystero-epilepsy which can be readily induced or cut short in the usual way. When in this mental state she says that her age is 21 next Christmas day. Her name is not really M—, but this name was given to her by a slave-dealer, who stole her away. She is the wife of a member of a noted firm of brewers. She has had "a large number of children." Married? "Yes." In church? "Church and chapel, and drawing-room too." She was in the asylum from which she has come for twenty months (really twelve years). She has never been there before, but E. M—, was there, and she (the patient) was brought from the South African war, and changed for E. M—.

Usually, however, this patient is in a very different mental condition. She is excitable, emotional, and quarrelsome, and suffers from frequent hysterical attacks which either do not react at all to suggestion or only stop for seconds or minutes. She is troublesome and noisy, and though she at times does a certain amount of floor-polishing and rough ward work, she is destructive, banging the deck-polisher about, tearing the casing off the heating-coils, etc. On one occasion she broke off the head of a deck-polisher, an act which must have required the exercise of quite a remarkable amount of force in the case of a woman. She is untidy and careless of her appearance. She becomes hysterical and bangs herself about if no notice is taken of her when one walks through the ward, whereas if she is noticed she either falls into a hysterical fit, or acts in a generally emotional and erotic manner. Under these circumstances she does not deny her name, and is too emotional as a rule to reply at all to questions.

The latter of these mental states is the common one and the former is relatively rare—so rare, in fact, that it was impossible to determine, during the time she was under observation, whether or not a sharp line of demarcation exists between the two states.

Group V.

EPILEPTIC INSANITY.

Epilepsy and mental disease.—As a preliminary to the description of this group of cases, it seems desirable to introduce certain general considerations bearing on the relationship which exists between epilepsy on the one hand and the entire subject of amentia and dementia on the other.

Epilepsy occurs in association with mental disease in three separate groups of cases in the general table which is inserted in the introduction to this paper, namely, in the first and fifth divisions of amentia and in the third division of dementia. The numerical relationship existing between the cases in these different groups is as follows:

	M.	F.	T.
Amentia. Group I.			
Idiocy and imbecility, Classes (*d*), (*e*), and (*f*) .	16	19	35
Amentia. Group V.			
Epileptic insanity	6	18	24
Dementia. Group III, Class (*b*) .			
Dementia following epilepsy . .	12	8	20
Total	34	45	79

The percentage of cases suffering from epilepsy out of the total of 728 is, therefore, 11 in the males, 10·6 in the females, and 10·9 in the whole series, and this does not differ markedly from the generally accepted average of about 10 *per cent.*

If, however, the groups of low-grade amentia, of high-grade amentia, and of dementia be considered separately, the following interesting relationship regarding the incidence of epilepsy in these different groups is obtained:

Idiocy and imbecility . .	94 cases,	37·2	per cent. of epilepsy.
High-grade amentia . .	189 „	12·7	„ „
Dementia . . .	445 „	4·5	„ „
Total. . .	728 „	10·9	„ „

Hence, whether the question be considered from the point of view of total cases, or, as is more correct, from that of the percentage co-existence of epilepsy and mental disease in the different grades of degeneracy, the statement may be made that, where cerebral degeneracy is greatest, epilepsy most frequently occurs in association with the mental disease. This fact is still further demonstrated when the group of epileptic insanity is divided into the following two classes—

	M.	F.	T.
Higher grade amentia without marked stigmata of degeneracy	2	6	8
High-grade amentia with marked stigmata of degeneracy	4	12	16
Total	6	18	24

for there are, again, more cases in the more markedly degenerate class than in the less. The evidence is, therefore, entirely against the thesis that the co-existence of epilepsy and mental disease results in cerebral dissolution, and is in favour of the view that both conditions are degeneracies.

Further considerations will now be adduced which tend to show that epilepsy nevertheless exerts a harmful influence on the subjects of mental disease who suffer from it.

An important difference exists, in the symptomatology following fits, between the cases of epilepsy and amentia and those of epilepsy and dementia. The former either rapidly recover from the convulsions or exhibit more or less marked psychic disturbance, and in neither of these types is there much, if any, mental confusion. The first of the types resembles in this respect certain ordinary "sane" epileptics, and the second those "sane" epileptics who, in a condition of post-epileptic automatism, are responsible for many eccentric acts and even crimes, of the commission of which, on recovery, they are entirely ignorant. In the case of epilepsy and dementia, on the other hand, the fits are followed by more or less marked mental confusion, which lasts for hours and even days, and after succeeding series of fits the existing dementia becomes gradually more profound. Some such cases, in fact, resemble examples of chronic dementia paralytica (general paralysis) in the point that numerous and severe fits result in an obvious increase in the degree of the permanent mental enfeeblement. It is thus evident that epilepsy acts, in relation to the subjects of mental disease, in a similar manner to that of the various forms of "stress," which determine the times of onset of first attacks or of relapses in high-grade aments, and therefore precipitate their confinement in asylums, and of mental confusion, resulting in mental enfeeblement, in cases which possess neurones of deficient durability. The psychic phenomena which occur in association with epileptic fits in all types of mental disease also afford an illustration of the general law that cortical neurones of deficient or subnormally aberrant development are not only less capable of resisting "stress" than are those of higher development, but are also more durable under the influence of such "stress" as that to which they may happen to be subjected, and that neurones of high development but deficient durability are more able to bear "stress" without interference with their functional activity, but, when the point of breaking-strain is passed, tend to undergo dissolution.

The influence of epilepsy on the psychic processes of the subjects of mental disease may therefore be thus summed up. In amentia of all grades co-existing epilepsy accentuates the psychic abnormalities which are characteristic of cases of cerebral under- or subnormally-aberrant development; and in dementia it increases the tendency to and the progress of

mental enfeeblement in cases possessing cerebra of deficient durability. The general effect of co-existing epilepsy is therefore harmful in all types of mental disease. The epileptic idiot or imbecile is more spiteful and degraded, the epileptic high-grade ament is more vicious and impulsive, the epileptic maniac is more treacherous and dangerous, and the epileptic dement becomes progressively more demented, than occurs in the cases of the corresponding types of mental disease when this complicating factor is absent.

Epileptic insanity.—The 24 cases included in this group have been divided, for convenience of description, into the following four classes :

	M.	F.	T.
(*a*) Epileptic mania in cases of higher grade amentia which do not exhibit marked stigmata of degeneracy	2	5	7
(*b*) Epileptic mania in cases of high-grade amentia which exhibit marked stigmata of degeneracy .	4	11	15
(*c*) Epileptic mania in a case of mild imbecility .	—	1	1
(*d*) Epileptic mania in a case of higher grade amentia suffering from mild senile dementia . .	—	1	1
Total	6	18	24

The isolated cases in classes (*c*) and (*d*) are accidental types. The former of these has passed the boundary of Group I, Class (*f*), which includes cases of mild imbecility with epilepsy, without entirely deserving inclusion in the above-mentioned Class (*b*). The latter, on the other hand, would have been included in Class (*a*) were it not for the incidence of senile involution, with consequent mild dementia. For the purposes of description Classes (*a*) and (*d*) and Classes (*b*) and (*c*) will therefore be considered together.

Group V. Classes (a) and (d).

Higher Grade Amentia, with Epileptic Mania.

Under this heading are grouped 8 cases, of whom two are males and six are females. One of the latter differs from the remainder in the fact that senile involution of the cortical neurones with consequent mild dementia has begun to develop.

The cases at present under description agree in the possession of ordinary intelligence and in the practical absence of stigmata

of degeneracy. In the examples in which a satisfactory personal history has been available, the incidence of the epilepsy has been delayed till puberty or even adult life has been reached.

The symptomatology of these cases is so well known that only the briefest reference here is necessary. The patients are unstable, irritable, and quarrelsome; and especially after, but at times in association with, fits they are liable to maniacal excitement, with outbreaks of impulsive violence. They are, as a rule, religious, and they are fond of attending services or of reading books dealing with spiritual matters. They associate together like ordinary sane individuals and at times make plans and plots against asylum government, and they frequently make enemies, often as the result of jealousy. On the whole they differ from the average sufferers from mental disease in being less selfish, self-absorbed, and callous to the troubles of others, and in being more self-conscious. They in some respects resemble criminals rather than lunatics, and may be described as degraded rather than degenerate.

The violent psychic disturbances which are characteristic of these cases may occur after or in association with fits, or they may follow "sensations," which are probably attacks of *petit mal*. The expression "sensation" may refer to an aura preceding momentary loss of consciousness, but in some cases it is apparently used to denote a mere feeling of malaise without visible loss of consciousness. The severity of the psychic disturbances bears no necessary or definite relationship to the type or severity of the epileptic attacks. Cases with severe or frequent fits may show slight mental symptoms only, and others with mild, non-apparent, or infrequent epileptic attacks may suffer from severe psychic disturbance. These cases as a class are probably homologous to the group of "sane" criminals who suffer from "masked" epilepsy, and who, in a condition of post-epileptic automatism, commit murders and other crimes.

In general symptomatology cases of epileptic mania resemble certain other groups of high-grade amentia. They most resemble cases of recurrent insanity (Group III), and also, but to a less extent, they show a resemblance to certain types of excited and "moral" cases (Group II). In some instances, in fact, the difference between the types appears to lie solely in the presence of epilepsy, which acts as the exciting cause of, and

increases the violence of, the recurring psychic disturbances which are characteristic of these cases.

The type of case under consideration shows as a rule less resemblance to cases with systematised delusions (Group VI), though examples, *e.g.*, No. 237, occur which might almost be spoken of as cases of abbreviated paranoia.

Cases of epileptic mania are frequently good workers. Both the male cases worked well, and of the six females, four, apart from occasional refusals, were excellent workers. The remaining two, owing to age and physical infirmities, were unable to do useful work.

The following two cases are inserted as illustrative examples:

Higher Grade Amentia. Epilepsy, with very slight Secondary Psychic Disturbance.

Case 235.—J. W—, male, single, bricklayer, æt. 34. Certified since the age of 27. In asylums at the ages of 26 and 25, and has shown symptoms since the age of 23. Mother suffered from paralysis.

A smiling man of pleasant appearance, who at once looks at me and asks if he is to sit down. He gives his name, his age, and his birthday. He knows the day, the exact date, when he came here, where he came from, and the exact date of his admission to that asylum, together with the period of his residence there.

He had his last fit five to six weeks ago. He usually has about one a month. They occur the first thing in the morning as he is getting up, or occasionally at night, whilst he is in bed. When the fit comes on he simply drops down, and he can get up and go to work directly the fit is over. If he has three or four fits in succession he feels "weak." He states that at the time of his admission to his last asylum he was violent after fits, but has since been well behaved. He passed the fifth standard at school, and the fits began at about the age of 14, the second or third year after he started work. He worked in the garden at his last asylum.

The patient, whilst under observation, was a useful and willing worker. He suffered from occasional fits, and psychic accompaniments were slight or entirely absent.

Higher Grade Amentia. Delusional State Resembling Paranoia. Epilepsy.

Case 237.—A. S. M—, female, widow, no occupation, æt. 42. Certified one year, and was twice in an asylum at the age of 26 and once later. Father insane.

A garrulous, excited, and highly neurotic woman. She gives her name and age and the date of her birth, and then asks "Why don't you look up

things instead of asking me ?" She knows the day and the date, where she has come from, and the date of her admission to that asylum. She states that her mother died five days before the last date. Then she asks me for a pair of scissors as she says she would cut off my hair and beard. On further examination, she states that she was the first of the Talbot family to be born on Rushton Park Estate. They are somehow a royal family. She was christened on the same day as some important person or other, and she then continues to repeat all kinds of inconsequent coincidences. She appears quite unable to appreciate the proper relationships to one another of external facts and occurrences. She strongly objects to my questioning her. She was married at the age of 26 (? true, as she was in an asylum that year) and has one son. She states that her husband left her a million pounds. She frequently calls me "fool" and "idiot." She is extremely egotistical. Whenever she sees the name Talbot (her maiden name) she fancies that it has something somehow to do with her. She is most abusive and is extremely garrulous. Her mental condition much resembles a kind of abbreviated paranoia.

Patient rapidly became acutely maniacal and continued so for several weeks, till she was nearly worn out physically. She then improved and settled down into a stationary condition which lasted during the time she remained under observation.

She is, on the whole, quiet and well behaved, but she is at times garrulous, fussy, and hypochondriacal, and at others grandiose. She would dress fantastically if she dared. She is not at all religious. She does not hoard rubbish. She is very clean and looks after herself. She dusts the dormitory and makes several beds, and at times does a little needlework. If allowed, she would never leave the ward, and she is not anxious to go either to church, to entertainments, or even into the airing court. Every few days she becomes more or less abusive but soon settles down again. She frequently complains about the food, etc. This is especially the case when she is menstruating and for about a week at this time the egg is invariably bad or the beef-tea is short, etc. In her business letters to her lawyer she tends to keep away from the point, to write inconsequently and verbosely, and to complain of persecution. She frequently, in her letters to strangers, writes about her private affairs. Her fits are rare but she frequently suffers from "sensations." The latter often occur about dinner-time and she has from three a day to nine a week. She "feels them more than fits." They cause severe headaches and make her feel "weak." In conversation she is intelligent and at times interesting. Her memory is perfect. She would often during a prolonged conversation pass for a perfectly sane woman.

Group V. Classes (b) and (c).

High-Grade Amentia, with Epileptic Mania.

This class contains 16 cases, of whom 4 are males and 12 are females. One of the latter is intermediate in type between this class and that of mild imbecility with epilepsy.

These cases occupy an intermediate position between the last class, *e.g.*, "higher grade amentia with epileptic mania," and that of "mild imbecility with epilepsy"—Group I, Class (*f*). The fits as a rule begin during the early years of life, and the cases usually show marked stigmata of degeneracy. The patients in many respects resemble overgrown children, and hardly a single example of the class would be capable at any time of passing as a sane intelligent adult, in this respect markedly differing from the cases of the preceding class.

In many instances these patients are bad-tempered, spiteful, quarrelsome, violent, and even dangerous. Other cases, however, are emotional and hysterical, and many of the "fits" from which these latter patients suffer, but especially those occurring during the day and under the influence of emotion, are indistinguishable from hysterical attacks. The fits which occur during the night are, however, more or quite typically epileptic in character.

These patients as a class are often very troublesome, but they quarrel together rather than combine in action. They, however, make friends as do sane people, and they are often favourites with the attendants and nurses. They are usually vain, and they are fond of decorating themselves with trifling articles of finery. They are frequently religious.

A large proportion of these cases were useful workers. Of the four males, one was a good, two were ordinary, and one was a poor worker ; and of the twelve females, eight were good workers, and the remaining four, who were all very violent and dangerous patients, were unemployed.

The following three cases are inserted for the purposes of illustration :

High-Grade Amentia. Epilepsy, with slight secondary Psychic Disturbance.

Case 242.—S. A—, male, single, labourer, æt. 34. Certified at the age of 28, and was previously in an asylum at the age of 24. Has suffered from fits since his birth.

An intelligent-looking man, with a receding forehead and chin, bright eyes, and a generally neurotic appearance. He gives his name and age, and the date of his birth. He knows the day and date in full, when he came, where he is, where he has come from, and how long he was there. He earned his living from the age of 11 years up to that of 24, when he first went to the asylum. He has suffered from fits for "some time, only just before I went to H—." (This is his only

incorrect statement.) Before a fit comes on he feels as if he were going to faint. If the fit is slight he remembers everything. If it is strong, "I loses my senses." He has no other aura. As soon as the fit is over he "feels all right" and shows no confusion. He speaks as a rule in rather a childish manner, *e.g.*, Can you read and write? "Yes." Have you been to school? "I went when I was a little boy, but I haven't been since." He writes well, he is generally intelligent, and he is a useful and willing worker.

High-Grade Amentia. Epilepsy, with slight secondary Psychic Disturbance.

Case 251.—K. L. J—, female, single, no occupation, æt. 35. Certified since the age of 30, and previously in an asylum at the age of 29.

A dark-complexioned, neurotic-looking woman, who smiles pleasantly. Teeth irregular and projecting. Palate very high and narrow. She gives her name and age, and says she has "been afflicted twenty years." She was "not unwell till 17." The fits came on at the age of 13 or 14 years. She knows the day and date, and where she is and where she has come from. She was previously in an asylum for four and a half months at the age of 29. Her illness "came on as screaming fits and upset the neighbours, and my doctor sent me there." She has only had two or three fits during the day. "They came on during my sleep." She feels quite clear in her head in the morning, but is sometimes sick, has a headache, and feels too ill to do anything.

Her memory is good, but she is childish, simple-minded, and hypochondriacal. She is sensible, well-behaved, clean, and a good worker. She is very obliging and does her work well. She is very religious and always remembers the text of the sermon in order to send it to her mother. She has no special friends amongst the patients. She, however, does a good deal of private needlework, and writes home regularly. She has had no fits for over a year, but frequently has headaches at the menstrual periods and "suffers in her back." At these times she often loses her memory for short periods or forgets things, and she is more than usually hypochondriacal.

High-Grade Amentia. Epileptic Mania.

Case 252.—A. S. P—, female, single, no occupation, æt. 31. Certified since the age of 27 years, and previously in asylums at the age of 17, 21, and 22 years.

A pleasant-looking woman of pale appearance. She gives her name, age, and date of birth. She knows where she is, when she came, where she came from, and the present day and date. She has been in "a place like this nearly 22 years." She has been three times previously in asylums, and three times in workhouses or hospitals. On the first occasion, shortly after her eleventh birthday, she fell into the fire, was severely burned, and was sent to the hospital. After her discharge from the hospital she had only been at home a few days when she was

sent to the workhouse, and she has since spent her life in workhouses or asylums.

When under sedatives she rarely has fits. She usually has one or two a month, and they as a rule occur during the night. When the new moon is about she "has sensations." She feels them most about her heart. The "sensations" do not always end in a fit, but when they do "I feels lost and hears myself laughing, and cannot stop it." When she has a severe fit she has no "sensation" at all, but falls down suddenly. She dreams a good deal at night, but especially at the new moon. She says she feels disagreeable at times. She is very hypochondriacal and garrulous.

As a rule this patient works well, and she is very clean and attends generally to herself. She is, however, very spiteful and interfering. She makes friends amongst the patients but cannot keep them. She is very jealous when other patients are taken notice of. She is extremely religious. Real fits are rare, but she frequently has "sensations." When they come on she begins to cry and sob. They are not followed by confusion, and when they are over she often says, "I feel better and that's for a few days more."

Group VI.

CASES WITH SYSTEMATISED DELUSIONS (INCLUDING PARANOIA).

This group contains ten male and sixteen female cases, the predominant characteristic of which is the existence of a sub-normally aberrant type of ideation which results in the development of a systematised series of delusions. Throughout the following description the term "paranoia," for purposes of convenience, will be used in a generic sense with reference to the whole group of cases.

As all cases of this type sooner or later develop ideas of grandeur, and in this respect resemble many of the "cranks and asylum curiosities" described in Group II, Class (*d*), it seems desirable here to compare these groups with their sane prototypes, in order to demonstrate the difference which exists in the processes by which, in the two groups of cases, these ideas of grandeur become evolved. The "delusions of grandeur" which frequently exist in cases developing or suffering from dementia will be referred to in the third part of the paper. It is sufficient here to state that the ideas of grandeur at present under consideration appear in consequence of developmentally aberrant ideational processes, whilst those to

be referred to under Dementia occur as a result of imperfect ideation in cerebra which are undergoing degeneration, or which are "mained" and consequently unable to perform their functions normally owing to previous degenerative processes. In the former type ideas of grandeur develop in consequence of definite and systematised processes of thought, however aberrant or abbreviated these may be, and, if the premisses were correct, the conclusions, except for exaggeration, would follow. In the latter type the ideational processes resulting in delusions of grandeur are largely unsystematised, and in many cases the mode of development of the idea of grandeur is simply a process of "going one better" by relative association as the result of the feeling of well-being. For example, a case of dementia paralytica, on being asked if he possesses a hundred pounds, may reply "A hundred? *Hundreds*, THOUSANDS, MILLIONS!," and an indefinite number of similar "delusions of grandeur" may readily be manufactured by appropriate interrogation.

The "crank," whether sane or insane, grades into the paranoiac, also whether sane or insane, and the essential difference between the two types lies in the process by which the idea of grandeur is developed. In the former type the evolution is simple and rapid, and the result may even appear spontaneous, whereas in the latter the process is complicated and gradual, being in the sane variety the natural consequence of a real "hard time," and in the insane that of a lengthy and grotesquely exaggerated system of persecution, which may, or may not, have any basis in fact.

The sane "crank" accepts or originates an idea which is contrary to accepted usage or scientific fact, *e.g.*, positive as vegetarianism, or negative as anti-vaccinationism, anti-vivisectionism, anti-taxationism, etc. He glories in his peculiarity, courts persecution, is insusceptible to argument or proof, develops a sense of responsibility as a reformer or an innovator, and, as a natural result, evolves ideas of grandeur.

The insane "crank" is simple-minded, peculiar, and erratic, or possesses ability in association with grotesque ideation and the resulting weird actions and eccentric general behaviour. Both types, in consequence of petting and spoiling, markedly develop their inherent vanity, and their aberrant association of ideas, occurring in the absence of any criteria of comparison, readily results in notions of grandeur. Even a patient with

intelligence little above that of an imbecile will, for example, believe in his royal lineage, in spite of the existence of a living father and mother, if he is told that he resembles the Georges and particularly such a personage as the late Queen in appearance; and the development of ideas of grandeur, when a patient actually possesses a certain capacity for painting or poesy, naturally follows still more readily.

The sane "crank," apart from his fixed idea, may or may not be a useful or even a prominent member of society. The sane "paranoiac," on the other hand, is frequently a person of ability, and not rarely has risen in social status by his own efforts. Such an individual as the latter may be described shortly by means of the one word "upstart." Men who have risen from the ranks in the army are at times domineering to their former compeers, and suspicious of and insolent to their present more-cultured associates. Women who have risen from the position of domestic servants may become dictatorial, domineering, insolent, and unjust to their present inferiors. Such cases are, to say the least, not of a high intellectual grade, or they would not so exaggerate their own performances and would be less ignorant of their own ignorance. Examples of sane paranoia in persons of higher capabilities or social status are, however, probably more numerous. A type of the sane professional paranoiac is, for example, a medical consultant who has for years had the greatest difficulty in earning his livelihood, or even in keeping the wolf from the door. He has during this period associated with successful men of his own grade, and his vanity has been fed by the adulation of students and nurses and by the feeling of pride that he is *not* an ordinary general practitioner but is a member of the higher grade of the profession. The lower the actual intellectual status of such an individual, the higher, when success eventually crowns his efforts—and these more often consist of obsequiousness, tact, and diplomacy than merit the name of scientific achievements—is his opinion of his position and importance. He is grandiose, domineering, consequential, and dictatorial, and his juniors or inferiors find it almost impossible to work harmoniously with or for him. A more common type of sane paranoiac than the professional is the social variety. An individual manages for years by the exercise of thrift and tact to live on the fringe of "society." He carefully

cultivates certain people, who are perhaps most undesirable or even unpleasant acquaintances, simply because of their social connections, he submits to any number of rebuffs and indignities, and he exercises an amount of tact and discrimination in his management of different people who may be of use to him from the social point of view, which, if employed for business purposes, might make him a fortune. The greater the difficulties such an individual experiences in continuing on terms of acquaintanceship with those whom he considers the elect, and the severer the hardships he has to suffer, the more he looks down on the common people—who not being in society have necessarily been manufactured by the Great Artizan from inferior materials—and the more arrogant and insolent is his behaviour towards them. The sane paranoiac is thus an individual who, owing to his limited mental range, views his personal experiences and capabilities through convex lenses and therefore develops intellectual stereotypism with ideas of grandeur. Whilst the "crank" concentrates his energies primarily on the accomplishment of an eccentric object which is not directly connected with his own welfare, the paranoiac devotes himself to the consideration of his own personality from the aspects of both experience and accomplishment, as if he were the one individual with brains in a world of fools.

The insane paranoiac occupies the status amongst cerebral degenerates which is filled by his prototype amongst the sane. He begins his life as a sane individual, and becomes out of accord with his environment at some period of adult life.

An example of the younger and more degenerate type is a man who, owing to real, but unappreciated, intellectual incapacity, drifts from employment to employment without realising that his services are dispensed with owing to his inability to perform his duties in such a manner as to justify their retention. Sooner or later such an individual develops the idea that he is badly treated, or that some former employer has actively endeavoured to deprive him of his situation. The particular idea of persecution which first develops necessarily depends on accident of environment, and many different imaginary wrongs may be considered and rejected before the basis of his future content of delusions is laid. He may, for example, see a younger brother placed in his father's business, whilst he himself is unable to keep in any permanent employ-

ment, and may, consequently, seek a reason for his father's fancied prejudice against him and discover his traducer in a family friend or medical adviser. The essential feature of such a case is a suspicion of others which will sooner or later foster definite ideas of persecution, and these, as the result of introspection, become gradually more intense, more systematised, and more likely to form part of the content of a permanent delusional state.

Cases of paranoia developing at mid- or late adult life agree in essentials with those occurring at an earlier period, but differ somewhat in their mode of origin. A clerk, for example, after several years of hard drudgery in a city office, becomes, owing to the monotony of his life and the constant mental strain of his duties, nervous and fidgety, and fearful of making mistakes. He may merely be afraid lest his uneasiness be noted by his colleagues, or they may actually talk about or even make a butt of him. Further, when in the streets, his nervous and absorbed manner or his furtive glances may cause people to look at him as they pass. He thus readily becomes suspicious and watchful, tends to apply to himself looks and remarks which really do not concern him at all, and eventually develops the mental condition referred to in the preceding paragraph. A married woman, again, who has for years lived a secluded and monotonous life, may, as the result of real or fancied trouble with her neighbours, develop the idea that they try to annoy her in various ways. Every action performed by them, every noise produced in their house, or every alteration made in the outside decoration of their premises, may appear to her to be done on purpose to annoy her ; and eventually similar ideas of persecution develop. In such cases, when the mental condition has already become such as to afford a suitable soil for the growth of the delusional state, this may spring up as the result of accidental occurrences, which would be without permanent ill effects on a normal individual, such as alcoholic excess, severe illness, monetary losses, or family troubles. In the cases of the first and second of these exciting causes, ideas of persecution may develop as the result of hallucinations of hearing secondary to cerebral toxæmia ; and the disorder may thereupon run a more rapid course. Many examples might be added to illustrate the various modes of development of what is finally a delusional state, but the above are probably sufficient to demonstrate the nature and origin of this condition.

The delusional state has at first no definite, or at any rate no fixed content; and the actions of the patient in some respects resemble the watchful and suspicious behaviour of an animal which has at one time suffered ill treatment, and is, therefore, inclined to look upon every stranger as a probable foe. The content of delusions develops more or less rapidly *pari passu* with the evolution of the delusional state. The patient lives in an atmosphere of suspicion, and everything said or done in his presence is subject to misinterpretation, and in some way or another is applied to himself. He broods over his fancied wrongs, and is constantly associating together expressions or actions which have nothing in common. The earlier delusions of persecution may constantly change until one or more of these is finally accepted and adhered to. Whilst the exact content of delusions at the beginning thus depends on accident of environment, this original basis is then constantly added to by a combination of the results of experience and introspection until a whole systematised superstructure of possible and impossible persecutory ideas is eventually elaborated.

An individual, for example, accepts the idea that his wife has committed adultery with some particular individual, and becomes gradually so suspicious and violent as eventually to require certification. He appears to lose the idea and is discharged from the asylum. During his detention his wife has earned her living by taking in lodgers. On his return the patient finds this out, and he concludes that she has been keeping a brothel during his absence, and has even been training her daughters in immoral practices. He says little or nothing, but watches her conduct, suspecting her all the time of immoral behaviour with every man she happens to be alone with. In consequence he develops the idea that even tradesmen and vagrants calling at the house have come for immoral purposes; and if his wife when out of doors speaks to a male acquaintance he suspects her of making an assignation. Finally, after more or less domestic trouble, associated perhaps with violence on his part, the patient is again certified, when without delay he begins to accuse his wife of causing his incarceration in order to remove him from her path. He then proceeds to suspect certain of the attendants of going to visit his wife when they are off duty, and either attacks them or endeavours to

make such complaints against them as will secure their dismissal. Such a simple type of case, if at large, would be likely to commit homicide sooner or later.

Almost any idea of persecution may serve as an accidental basis for the development of a systematised content of delusions, but in the more typical cases the original persecution has been carried on by some particular individual, and in at least many instances the idea contains an exaggerated and misinterpreted basis of fact. The patient then, as the result of prolonged introspection, succeeds more and more in blackening the character of the persecutor, who eventually becomes in his eyes an incarnate spirit of evil. The more diabolically ingenious the persecutor proves himself, and the wider the net which he has spread for the unfortunate patient, the more and more persistent becomes the question "Why is he so persecuting *me*?"

At this point the patient becomes almost desperate, and during alternating periods of grotesque exaggeration of his ideas of persecution, and of comparative sanity, during which he laughs at the opinions he has expressed, the grandiose stage of the delusional state begins to make its appearance. The patient has often hitherto been more or less reserved regarding his "case," but he now becomes abnormally garrulous, and repeats a minutely detailed description of this whenever he can obtain a listener. He worries everyone around him, and especially strangers, with a full account of his sufferings, and endeavours to obtain their opinion and advice. According to the temperament, the previous experience, and the present environment of the patient, the persecutor may be employing secret service agents, who later are associated with secret societies of world-wide influence, or detectives, who are Jesuits in disguise, and who gradually come to employ the whole mediæval power of the Roman Church to compass his destruction, or secret police, who watch him lest he should by chance escape and influence the political situation in England, Europe, or the world. One patient, when almost despairing of finding an explanation why his enemy had obtained his incarceration in an asylum, suddenly remembered an illegitimate child of his who was at that time about twelve years of age. He knew nothing definite concerning the history or connections of the mother of the child, and eventually, after thinking the matter over, concluded that she was probably of royal or august

parentage, and had been stolen in infancy and hidden away under the guise of poverty. He hence concluded that *he* was incarcerated lest he should discover these facts and claim the throne on behalf of his daughter.

When the persecutory ideas of the patient have thus passed from the possible to the impossible, accident of environment will soon cause him to develop some definite idea of grandeur. The death of a king or queen, the Pope, or an important political or social personage, etc., at once leads him to apply for the vacancy, and after several tentative titles he eventually fixes on one, and the case is then fully developed.

As the result of constant repetition and introspection the personal history of the patient has by this time become stereotyped and abbreviated, and his description in some instances becomes almost unintelligible without the key furnished by a previous knowledge of the case. The patient is an emperor, a general, the Prime Minister, etc., and round his grandiose account of himself are fossilised the remains of, usually, his later delusions. At this, the fully developed stage of the disorder, it is common to find the patients willing to work usefully, whereas during the earlier and persecutory stage they frequently refuse to do any work whatever.

The period of time required for the full development of the paranoiac varies from a few to very many years, and numbers of patients die before they reach the final stages of the disorder. Frequently the pre-senile or even the senile period of life is reached before the case is fully developed, and it may then be complicated by the incidence of involution of the cortical neurones, with consequent mild dementia.

Both the mode of development and the general characters of the mental symptoms of paranoia are markedly influenced by the degree of education possessed by the individual sufferers. Educated patients reason well and even acutely, whilst uneducated subjects find great difficulty in expressing themselves, reason in a faulty manner, and make weird mistakes from ignorance both of the terms they use and of the exact connotation of these. Such patients, on the advent of a new invention or discovery, at once apply this to their own case, and not only get hold of the new word inaccurately, but also apply the process or fact in some grotesque manner, which however is in strict accord with their own limited knowledge and experience.

Errors of this nature have to be carefully allowed for during the study of the mental processes occurring in this class of patient.

From what has already been stated, the existence of aberrant forms of the general type of case which exhibits systematised delusions is readily intelligible ; and unusual exciting causes, particularly when hallucinatory phenomena result from these, frequently give rise to an unusual symptomatology and to an entire modification of the general course of the case. It is also especially difficult to determine where the group of "asylum cranks" ends and where that of systematised delusional cases begins. In this respect, however, the group of cases under consideration resembles the other groups into which cases of amentia have been divided. All the groups grade insensibly into one another, all excepting the first, which contains idiots and imbeciles, possess their sane prototypes in the outside world, and all agree in exhibiting to a greater or a lesser degree the essential characteristics of deficient or subnormally aberrant cerebral organisation, and, apart from senile involution of the cortical neurones or degeneration of these from accidental extraneous causes, of absence of cerebral dissolution and consequent dementia.

Of the 26 cases which are included in the present group, and of which a considerable proportion had reached their full development, the majority were useful workers. Of the 10 males, 8 worked very usefully, and of these 3 were early cases and 5 were more or less fully developed ; one, an early case, refused to work, and one, a fully-developed case suffering from senile involution of the cerebrum, was an ordinary, but useful, worker. Of the 16 females, 8 were good workers, and of these 2 were early cases and 6 were more or less fully developed ; one early and 2 developed cases refused to work, one early and 2 developed cases were ordinary workers, and one fully-developed case suffering from senile involution of the cerebrum and one fully-developed case owing to bodily illness were poor workers.

The following six cases are inserted for the purposes of illustration :

Delusional Insanity, Pseudo-Hallucinations, Mild Dementia.

Case 258.—D. E—, male, married, labourer, æt. 62. Certified since the age of 57, and symptoms for some time previously.

An intelligent-looking old man, who is very deaf and therefore shouts loudly during conversation. He says that his deafness is due to a blow on his head from a shovel. He makes a whistling noise with his tongue and teeth as he talks. He gives his name and age, and the day and date, and knows where he came from and where he is. He strongly objects to the name "Hellingly." He thinks "heavenly" might trend to the good of the inmates, but the present name of this place is blasphemous. He thinks "people ought to be very careful in giving names to places. There is plenty of obscenity on the earth without making it by such names. There is too much dancing, etc., at music-halls. People transmit disease from hand to hand, and breath to breath, while dancing." He then continues for some time to protest strongly against the obscenity of dancing. He will not believe that the practice came from the East, either from the Holy Land or the Mohammedans. I then interrupt him with a question or two about dates, and make a remark about newspapers. This causes him to begin again, and he makes severe remarks on the abuses of asylums, and about newspapers in general, and the favouritism of giving newspapers to some inmates and none to others. He does not blame all the officials, though most are of no use. A few are, however, valuable, and one was kind to him. After a few personal questions he tells me that he hears voices at night. His mother comes and talks to him then. She weeps over him, as he has found her tears on his cheeks; and this recollection or inference causes him to become emotional. He then tells me that some time ago he was listening to Her late Majesty Queen Victoria and Mr. Gladstone. They were speaking in a little chapel, and he could see them most clearly. In confirmation of this he tells me that he knows the site, etc., of the chapel in question. This occurrence was before the late Queen died. A few days after it Mr. Gladstone died. He says that long before she died he prophesied the exact day and date of the death of the Queen. This remark *apropos* the subject of prophecy causes him to say that he has seen it raining fire from heaven in Eastbourne. "Oh, it was something fearful and a Divine punishment for drinking so much evil spirits." He now becomes grandiose rather than dictatorial and prophetic, and states that his father was a prince and his mother the rightful heiress to the crowns of England and Spain. Her name was Jane, Jeanne, etc. He himself is the Earl of Sapton, Duke of Clarence, Kent, and Lancaster, by right. He, however, was proscribed. He has a scar on his right side (correct), which is like a crown (imagination), and he says that it is upside down for this reason (*i.e.* he thinks that the scar looks like a crown upside down, and that it is placed thus both to identify him and to show that he is proscribed). His "mother was buried in a gold crown, and the Crimean war was fought over her poor carcase."

When the patient gets excited, his ideation becomes rapid, and he gesticulates and discourses as the result of vivid pseudo-hallucinations. He is a decent old man and a fairly useful worker in the tailor's shop and the ward. He is most punctilious in the performance of his duties, and does his work slowly and very carefully. He is, however, so interfering and fault-finding when in contact with other patients that he only works satisfactorily for any length of time when kept quite by himself.

Developed Paranoia; Onset in Early Adult Life.

Case 261.—T. H. T—, male, married, musician, æt. 39. Certified since the age of 32 years.

An intelligent-looking man of dark complexion, and with elevation of the outer canthi. He gives his name and age, and his knowledge of time and place and general intelligence and memory are normal. When asked if he is a musician he replies "Three right sides" (*i. e.* he is a man with three accomplishments), "recitation, singing, and violin-playing. Taste for poetry-writing and so on." He has a pretty good all-round talent, if he is allowed to get it up. He then offers to give the asylum people two millions. "No limit, I think, scarcely" to his possessions. A hundred thousand is enough for his own pocket. He is above crowned heads in finance, but keeps in a medium position to stop jealousy. He hears "a sort of muttering, a little by-play, a way they have of explaining a little roundabout affair over this long life system." Asked what this is, he says that people can call him the "rightful prolonger" on account of the long life system he has started. "A man can live a thousand years through bleeding, as the anatomy gets harder every year one lives, from the pulp of a baby to the hardness of a man, by keeping from all diseases, as one's whole anatomy hardens, barring one's teeth, unless attended to." He says that these ideas arose from a dogbite when he was a youth. He bled a basin of blood and felt so well after that he "has tried and proved these ideas correct," but then he has "a very penetrating mind." When questioned with the object of eliciting a persecutory phase to his mental state, he replies that all through his life certain people and the police have had a modified way of annoying him. They castrated him to a certain extent, making his testicles nearly as small as a hazel-nut, but they are now improving. He thinks "a little trick was going on," but he does not know who his persecutors were.

The patient is a good worker, and is an excellent player on the violin. He is a member of the asylum band, and at times plays solos. He is solitary in his habits, and is liable to become violent and dangerous if interfered with.

Developed Paranoia. Onset at the pre-senile Period of Life.

Case 264.—J. H—, male, married, farm bailiff, æt. 64. Certified since the age of 53, and was previously in an asylum at the age of 49. Brother insane.

The patient is a pompous-looking old man with a long white beard. He gives his name, age, and birthday; he knows the exact day and date, where he is and where he has come from and when he came, also the exact date when he first went to an asylum, and the exact dates when he was transferred from asylum to asylum during the past eleven years. His memory and intelligence, in fact, appear normal, and the former is acute.

He then, observing that I am taking notes, slowly dictates as follows: "The 17th of August was the day, in the year 1825, when old Farmer

Gilbert Henry Thomas Fowler used the means of getting mother Ann Longley, daughter of William Longley, and in due time her first-born son was born. He signed a cheque 'Henry Carrington Smith' for me, and was really J. W. Fowler Longley." He tells me this "to show what a beastly bad fellow that a' been." On careful inquiry I find that he does not suffer from hallucinations, but "everybody seemingly is my enemy. . . . Why should I not have my liberty, but herd with a lot of notorious whores, rogues, and vagabonds?" . . . "John William Fowler Longley is the man who will have his way. He killed two children in the docks at G—. I didn't see him, but am sure that he did so. He also killed three in the docks at L—. He tried to shoot me and got other folks as was lunatics to do so, and I had to sleep in the same dormitory at H— with them." On further examination, patient states that his mother "was used by three lions, two lions and a lioness, after being knocked down at Gloucester, Wombwell's show," and that therefore he is "Coer de Lion." He is also the first cousin of the King of England, as his father and the King's father were own brothers.

The patient is an extremely decent and intelligent old man and is a good and willing worker. His mental condition has now obviously long been stationary, and a study of the above description shows that he has got to the "abbreviation" stage in his delusional state, although, as he refers to the *King* of England, he is still continuing to add to his content of delusions.

Developed Paranoia. Onset at the Pre-senile Period of Life.

Case 271.—M. H—, female, single, lodging-house keeper, æt. 66; certified since the age of 57. States that she has a sister insane.

A pleasant, but dignified-looking old woman, with an expressionless forehead which does not move when she smiles.

She at once begins to tell me that she was kidnapped at W—, in place of someone else, eleven years ago, and placed in F—. She had a sister there also, and the latter was quite well enough to be out. "Nothing much the matter with her." Patient gives the following account of her own incarceration. She was in W— and heard a voice saying, "Go to the Town Hall for your ticket." She also heard a gentleman asking her what she was doing there at that time of night, and then heard someone say it was a detective. She thereupon went to a police-station at W— and asked if there was a letter or papers for Miss H—. She indignantly repeats that she "never asked for money." She was then taken to the infirmary. She denies that she ever had anything to do with any sailors. She insists on the respectability of her lodgers, and says she had many enemies who wanted to get her out of her house and keep her out of prospective money. She talks then a good deal about money and legacies and cheques which were to be, or might be, obtained by her. She gives a long and somewhat rambling, but perfectly coherent, account of her incarceration, the striking feature of which is that, whilst she will talk indefinitely if left alone, she will not attend in the least to what is asked of her, but at once abruptly denies it or refuses to reply. The reason for her behaviour is that every word

one says is understood by her to mean that one is trying to get at her in some way or other, in order to obtain evidence of her insanity by misinterpretation of her remarks. After spending a little time in reassuring her in this respect, one is able to get her to reply to ordinary questions. She then gives her full name and states where she is, when she came, where she has come from, and the day and date. She also states how long she was in her last asylum. To a question concerning her age, however, she whispers that the patients near are noticing; it is better, as she is sane, that they should not know.

During her residence she was very dignified and grandiose; she decorated herself with ribbons and pieces of dress material, and was very careful about her hair. She made her bed and attended most carefully to herself and her belongings, of which she possessed a quantity. She sewed very well and neatly and was very industrious, but absolutely refused to do any ward work. She was at times abusive and disagreeable, and was very eccentric and disinclined to make friends. She misconstrued what was said to her when spoken to, and was very suspicious. She considered the people around her spies sent to watch her, and at times remarked that other patients were wearing articles of clothing belonging to her. She would never have a second helping at meal-times unless she herself handed her plate to the charge nurse. On one occasion when excited she was ordered a dose of calomel, which was given in a cup of tea (!) by an inexperienced nurse. There were, she noticed, eight patients at the table and also eight cups set out. The nurse brought in a ninth cup and set it before her. She at once was suspicious, examined the tea, found the calomel, refused to take her meal, and, when she saw me, accused the nurse of attempting to poison her. This incident is a good instance of her general shrewdness, and on many occasions similar occurrences were noticed.

Paranoia passing into the Final Stage. Onset in Early Adult Life.

Case 278.—K. L—, female, married, housewife, æt. 35. Certified since the age of 34. Was, shortly before this age, in an asylum for some weeks, and has shown symptoms since her youngest child was born, four years ago.

A smiling, but fatuous-looking woman, with bright eyes, an expressionless face, and many fine horizontal lines on her forehead. She gives her name and age, and the day and date in full, and states exactly where she is, when she came, where she has come from, and the exact dates of her detention in asylums. She states that she went to the asylum to visit a friend and they kept her there. She does not know how the mistake arose, as both her husband and brother want her out. In fact, she says, her husband has many times brought her clothes to the asylum, but the authorities would not let her go. She says that "a man next door" wanted their cottage for a friend of his, and that he sent her to the asylum in order to get rid of her, and so get her husband, when the housekeeper was gone, out of the cottage. The "man next door" began to get things at shops in her name in order to get her into trouble. He went by the name of Fred Bray. She seems to

doubt whether this was his real name, as he only got 23*s.* a week and a cottage, and still went to Brighton and to theatres, etc. People thought that she was interfering with other people's affairs. She has not done so unless they know her thoughts, and her thoughts wouldn't do any harm to anyone. She thinks that the "man next door" hypnotised her husband and then herself, as her husband once gave her a black eye, and he had never done so before. This man had power to do an injury to anyone who wished her well. "These people had no business to write to other people about me; it's forgery. If he has killed one he has killed hundreds. He outraged my little Bessie, aged 8, a pretty little girl. Such fellows deserve roping. It's a pity God lets them live, I think. If he hadn't something he wished to hide, why did he try to pass my friends off as his? He has taken our name and passed in a sense as my husband." She is very garrulous, and has a rather childish way of talking. She is extremely suspicious, and when I ask questions about her children, etc., she wants to know why, and then asks if I have any children myself. When I reply "No," she says, "Perhaps you are like the 'man next door,'" and "Perhaps you have plenty in the workhouse."

During her residence she was often excited, and was extremely garrulous and suspicious. She frequently wrote long letters dealing with her case, and the ill treatment to which she thought she was subject. At times she would work hard, but as a rule she refused to work. Latterly, as her mental state was passing into the next phase, she used to think at times that she was really the medical officer, and used to ask for her salary and her uniform, and to state that it was her intention not to undertake her duties unless these were provided. At other times, again, she denied all this and made her more usual demands for her liberty and for large sums of money on account of her detention, threatening all kinds of criminal proceedings and penalties.

Developed Paranoia in a Patient of Deficient Education.

Case 281.—E. K—, female. Æt. approximately 40–50, but difficult to judge. Certified 5 years.

A phlegmatic-looking woman who screws up her mouth and smiles. Very stout. Lateral spinal curvature. Palate deep and narrow in front. Enormous lobules to ears. When asked her name says, "I'm known by that name" (pointing to admission paper), "but it's not my name." "I take Black as a surname." Christian name? "Victoria." "I sit next the crown. I have the income equal to the position, a thousand a year and a fortune." "I accepted ten thousand as a settle, waiting so long, kept out of it so long." Her memory and general intelligence are practically or quite normal for an uneducated woman. She was in her last asylum "five years and a half quite, not for any lunacy, political." There has been an "immense plot to keep me out of my rights, almost from birth, not quite." She states where she is, "H—, I'm told, but not the original." How not? "Because they reversed the station for bettering political matters. I recognised as I came along that it was so." She hears voices at night. "Some friends

of ours followed me here on political matters, and we have verified the case that I carried the crown. *It came out grandly last night.* We've really conquered the whole of Europe through coming here. The last is a great Richard's king case of course." Regarding her capacity for work she states that she sews well, but "I'm a first-class certificated mistress by profession."

During her residence she was dull and phlegmatic, and did very little work. Her mending often had to be unpicked, and she would work at a garment for weeks without finishing it. She used to tear up music and new newspapers, and was careless of her belongings, and left them about. She made her bed and attended to herself. She often wrote letters, especially to the Commissioners of Lunacy or the King. She thought that the charge nurse, when she went out of the building, received messages for her from different parts. She was very grandiose, but was quite satisfied with the food and with her surroundings. She never interfered with other patients, but got on her dignity if anyone interfered with her.

PRINTED BY ADLARD AND SON, LONDON AND DORKING.